Patient Weight History

Patient Label

Name:_____

1) **At what age did you start having weight problems?** _____

2) **What is your current weight?_____How long at this weight.?_____**

3) **What is your usual weight?_____**

4) **What has been your lowest weight as an adult? _____highest ?_____**

5) **What are your reasons for seeking weight loss now?** _____

_____

6) **Does your weight place limitations on your daily activities such as walking, tying shoes, or maintaining your personal hygiene?** (Please list the things that are diffucult for you now) _____

_____

7) **Do you have hobbies or activities you enjoy but cannot do anymore because of your weight?** _____

_____

8) **Do you think there are particular events that have caused you to gain weight in the past?** *(Please circle all that apply and list any others)*

Stress	Starting college	Fast Food	Don't like exercise
Work	Marriage/Divorce	Eating out	No time to exercise
Depression	Having children	Travel	Lack of support
Temptation	Medications	Medical reason	Illness/Health problems
Family crisis	Alcohol	Injury/Accident	Psychological problems
Busy lifestyle	Drugs	Quit smoking	Lack of will power

Other: _____

9) **What diet programs, supplements, or therapies have you tried in the past?** *(Please circle all that apply and list any others)*

Accupuncture	LA Weight loss	Slim Fast	LEARN
Atkins	Liquid diets	South beach	Quick Trim
Dietitan visit	Medifast	Sugar Busters	Others: _____
Grapefruit diet	Nutri-system	TOPS	_____
Hypnosis	Optifast	Weight watchers	_____
HMR	Pritikin diet	The Zone	_____
Jenny Craig	Regular exercise	Behavior modification	_____

10) What prescription and nonprescription medications or herbal supplements for weight loss have you taken?

Amphetamines	Metabolife	Xenical	Topamax	Laxatives
Adipex	Herbalife	Meridia	Ephedra	Other: _____
Fastin	Phen Fen	Orlistat	Dexatrim	_____
Pondimen	Redux	Sibutramine	Trimspa	_____

11) Did you have long term (>1 year) success with any of the items listed in questions 9 and 10? If yes, please list them. _____

_____

12) How do you feel about exercise? (please circle)

Love it Like it Can tolerate it Don't like it

13) Do you currently have an activity or exercise program? Yes No
If yes, what do you like to do? (please circle or list activity)

Walking	Weights	Yoga
Bicycling	Swimming	Other: _____
Aerobics	Dancing	_____

Frequency: (circle) 1 2 3 4 5 6 7 days per week

Duration/Distance:_____

Are there reasons why you can't exercise? _____

14) How confident are you that you can lose weight at this time? (please circle)

Very Confident Confident Sort of Confident Not Confident

15) Do you have time to work on weight loss right now? Yes No Maybe

16) What is your stress level at this time? (circle the appropriate number)

High 10 9 8 7 6 5 4 3 2 1 Low

17) Do you have friends or family that you can rely on for support as you attempt to lose weight? If yes, who? _____

_____

18) What do you think will help you the most to lose weight? _____

_____

_____

19) Are you willing to make long-term changes in your behavior to lose weight? Yes No

Please sign: *(By signing below you are acknowledging that the information you have provided above is correct to the best of your ability and knowledge.)*

Patient Signature:_____**Date:**_____